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ABSTRACT

This paper examines the current status of U.S. children's mental health and its impact on children's ability to learn. It notes the incidence of mental disorders in children, risk factors predisposing children to mental disorders, and symptoms of children with serious emotional disturbances. It explores the school-based and community-based services available to address children's mental health needs and suggests policy and action steps to improve the provision, availability, and accessibility of these services. The paper describes several models of collaboration among schools, community agencies, professionals, and parents. These models work to both treat and prevent mental health problems. Recommendations are offered in the areas of training, staffing, legislation, advocacy, and coalitions. The paper concludes with an annotated list of four organizational resources. (Contains 12 references.) (JDD)

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Children's Mental Health and Their Ability to Learn

National Health/Education Consortium
Occasional Paper #8

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National Commission to Prevent Infant Mortality
Institute for Educational Leadership

Children's Mental Health and Their Ability to Learn

National Health/Education Consortium
Occasional Paper #8

by

Sandra J. McElhaney, M.A.
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National Mental Health Association

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Foreword

America's children are growing up in a turbulent world, where poverty, single-parent households, drugs, and violence are becoming daily realities. Amidst this turbulence, an alarming 12 to 15 percent of America's children suffer from mental disorders. Children who have, or are at risk, for mental disorders have the odds stacked against them in school. A child who is angry, frustrated, afraid, or sad cannot be expected to learn.

In our present health and social service system, no agency alone has sufficient resources to treat all the children who need mental health care. No single agency can offer a buffer against the extreme stresses that many of our children face. What is needed is a concerted, collaborative effort on the part of health and mental health professionals, educators, communities, and families focus on the mental health of all children — those at risk and those who already have a mental disorder. It is vitally important that children's mental health services be provided, not as a confusing patchwork of offices, but as a well-integrated, community-based continuum of care.

A call for such collaboration comes from the National Health/Education Consortium (NHEC), a coalition of 57 national health and education organizations, in a report by the National Mental Health Association (NMHA) entitled, "Children's Mental Health and Their Ability to Learn."

"Children's Mental Health and Their Ability to Learn" highlights the fact that our health and social service systems do not address children's mental health issues the way they should. Although many treatment and prevention services have proven successful over the years, they represent but a skeletal framework of the services millions of our children urgently need. In the case of school-based mental health services, for example, there continues to be a vastly disproportionate ratio of students to mental health professionals. Similarly, while much rhetoric has been devoted to the provision of preventive mental health services to children, such services have yet to become a priority among policymakers, and health, education, and social service practitioners at the federal, state, and local levels.

Given the growing need for children's mental health services, implementation of coordinated treatment and prevention plans must become a priority nationwide. A system supportive of children's mental health must be established. Proposed action areas for collaboration include:

- increasing the number of mental health professionals in schools;

- appropriating adequate funding for child mental health treatment and prevention programs;
- ensuring that community mental health agencies work with and provide back-up services to school systems;
- training educators and school health personnel in the mental health skills necessary to facilitate the development of a school climate conducive to sound mental health in all students; and
- integrating successful prevention models in school systems across the country.

Since May 1990, the National Health/Education Consortium has been an advocate for better integration of health and education programs, services, and policies for children. NHEC hopes that this report will serve as a catalyst for action, bringing to the forefront the importance of systematically addressing a child's mental health needs as part of that child's complete state of health. Only through collaboration and cooperation can we ensure our children are mentally healthy and ready to learn.

— *National Health/Education Consortium*

Children's Mental Health and Their Ability to Learn

by Sandra J. McElhaney, M.A., Matt Russell, Heather A. Barton

Maria's third grade teacher has noticed that Maria has become withdrawn. Once a chatty and vivacious 8-year-old, over the past month the young girl has become pensive and fretful. The homework assignments which she once handed in with pride were now sparse and often ignored. No longer did Maria skip rope and giggle with other young classmates during recess... One day after class, Maria's teacher asked her what was the matter. The child broke down into tears, exclaiming between sobs that her father had moved out of the apartment where she and her mother live...and it was all her fault because she was a bad girl...

Douglas' English teacher sent him to the principal's office again... for the fourth time this week. The adolescent had kicked over his desk when caught cheating during a test. Douglas violently cursed the teacher and stormed out of the classroom. Walking in the opposite direction of the principal's office, he lit a cigarette. Feeling worthless, Douglas left the school building and headed toward the vacant lot where his gang usually hung out...

Introduction

Millions of children like Douglas grow up in America under the burdensome weight of mental disorders. Millions more like Maria are at risk. Childhood mental disorders can turn even the simplest of activities into a struggle. For many youth, getting out of bed each morning and getting dressed for school is a daily battle. Sitting through a regular seven hour school day can be even more of a challenge.

America's children are at risk for poor mental health. Poverty, homelessness, parental divorce, violence, and a surge in drug use are only a few of the many hazards that today's youth must confront on an increasingly routine basis. In all but the most resilient of children and adolescents, consistent exposure to these hazards in the absence of intervention can easily lead to any of a host of tragic outcomes for youth: school dropout and delinquency, teenage pregnancy, substance abuse, and mental disorders. Indeed, school dropout, teenage pregnancy and substance abuse are themselves risk factors for mental disorders. The consequences of childhood mental disorders can be severe and profound — both in terms of quality of life for the children and their families and in terms of the long-term impact on our nation's economy.

Children with mental disorders have the odds stacked against them in school. Many of these kids require intensive, specialized services, which are seldom available. Educators are often ill-equipped to teach them, and there are not enough specially trained mental health personnel and special education teachers to meet the demand. Such children are generally warehoused in special education classrooms where they are labeled as "failures." Many factors contribute to this situation. Inadequate federal and state funding, insufficient teacher training, and a general lack of awareness about children's mental health needs have helped to build an education system that is at best indifferent — and at worst — hostile to the needs of children with mental disorders.

The outcome of this scenario is dismal. Absent from a supportive school and community environment, children with mental disorders are at great risk for school failure in the short run and dependence on public resources and programs (i.e., mental health, substance abuse, justice, welfare, public health, and criminal justice) in the long run.

Families, mental health, health, and education professionals must work together to ensure the provision of the best services in order to meet the growing mental health needs of our children. Such services should be incorporated into an integrated system that is responsive and respectful of the needs of the child and his/her family.

The good news is that children with mental disorders can succeed in school and grow up to become productive members of society and similarly, children at risk often can completely avoid the onset of disorder. However, in order to provide for the mental health needs of our nation's children, a well-integrated, community-based continuum of care, incorporating a full spectrum of preventive, treatment and rehabilitative services, is needed. While the technology is available, the will to carryout the technology is not. Families, mental health, health, and education professionals must work together to ensure the provision of the best services in order to meet the growing mental health needs of our children. Such services should be incorporated into an *integrated system* that is responsive and respectful of the needs of the child and his/her family.

Since it was established in 1990, the National Health/Education Consortium (NHEC) has contended that children must be healthy to be able to learn, and they must be educated to keep themselves healthy. The Consortium has advocated that a child's health — and therefore ability to learn — is dependent on many things: nutritious food, shelter, adequate sleep, exercise, immunizations, and an unpolluted environment among other needs. In this paper, the National Health/Education Consortium and its member organization, the National Mental Health Association, want to stress that health requirements are not merely physical — health is a complete state of physical, mental, and emotional well-being.

"Children's Mental Health and Their Ability to Learn" examines the current status of children's mental health and its impact on children's ability to learn. The authors explore the services presently available to address children's mental health needs and suggest policy and action steps to improve the provision, availability, and accessibility of these services.

Background: How Mentally Healthy Are America's Children?

Mental health and mental disorders can be conceptualized as two endpoints on a vast continuum. Those with good mental health are said to not only be absent of mental disorders but also able to negotiate the daily challenges and social interactions of life without experiencing cognitive, emotional, or behavioral dysfunction.[1] Most people experience minor fluctuations in mental health, however, those with chronic and persistent mental health problems may be diagnosed with any of the hundreds of conditions classified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.[2] According to this publication, mental disorders are "clinically significant behavioral or psychological syndromes or patterns that occur in a person and that are associated with present distress or disability, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom."

...12-15 percent or 7.5-9.5 million children in America suffer from mental disorders including autism, attention deficit and hyperactivity, conduct disorder, depression, and alcohol and other drug abuse.

It is estimated that 12-15 percent, or 7.5-9.5 million, children in America suffer from mental disorders including autism, attention deficit and hyperactivity, conduct disorder, depression, and alcohol and other drug abuse.[3] The National Commission on Children notes that a particularly troubling, if not ominous, indicator of mental health problems in children is the increasingly rising incidence of suicide. Depression is cited as the number one risk factor for suicide among children. Between 1980 and 1989 the suicide rate for youth age 10-19 increased 30 percent, and a 1991 survey found that as many as 1 in 12 high school students in this country had attempted to take their lives.[4] According to Dr. Robert Friedman, Chair of the Department of Child and Family Studies of the Florida Mental Health Institute, "Never before have so many children and adolescents in our country suffered so much...From the perspective of prevalence rates of emotional and mental disorders, seriousness of the disorders, age of onset and relationship to other problems, the situation has never been so bad."

A Nation of Children "At Risk"

Many factors impact on children's mental health. Loving, firm parenting, a sense of security, opportunities for success, and the chance to develop personal and social competencies are all integral ingredients to "good" mental health. However, even children who grow up in the best of all possible circumstances with loving families, safe community environments, and good school experiences are not immune from developing mental disorders. The scientific community has determined that a complex interaction of variables including genetic risk, chronic medical conditions, and environmental factors can all affect the mental health of children.

While it is difficult to estimate how many children in this country are at risk for mental disorders, it is clear that a growing number of children are subject to multiple conditions that place them at risk.

While it is difficult to estimate how many children in this country are at risk for mental disorders, it is clear that a growing number of children are subject to multiple conditions that place them at risk. A 1990 report of the National Advisory Mental Health Council[5] identified a number of factors that can place children at risk for mental disorders. According to this report, *National Plan for Research on Child and Adolescent Mental Disorders*, these factors include the following:

- **Genetic factors**: Almost all of the physical traits and many of the behavioral characteristics of each child are dependent on hereditary make-up. The same natural forces that make a child's eyes blue and hair brown can cause disease and illness, including disturbance in the brain, or make an individual particularly vulnerable to depression, anxiety, and attention problems, etc.
- **Biological "insults"**: This includes physical trauma such as head injury or exposure to toxic chemicals or drugs.
- **Poor prenatal care**: This leads to increased risk of premature birth, low birthweight, and a host of related problems that can affect physical as well as mental development. Teenagers and women who live in poverty are particularly vulnerable.
- **Chronic physical illness**: Children and youth with an existing medical problem such as leukemia, diabetes, asthma, epilepsy, cystic fibrosis, and AIDS, seem particularly vulnerable to mental disorders. This can be attributed, in part, to the obvious additional stress these illnesses place on their lives, and in part, to the impact of resulting physical problems on their mental health.
- **Cognitive impairments**: This includes impairments resulting from mental retardation, as well as deficits in sensory perception, including deafness and blindness.

- **Persistent psychological adversity**: Millions of children face the persistent psychological adversity of poverty, disorganized and inadequate schooling, and homelessness. Sadly, more than 20 percent of American children live in poverty, and more than half of these children live in single-parent homes. Increasing numbers of children have no home at all.
- **Child abuse or neglect**: More than 1.5 million children are reported abused or neglected each year. These children are not only at increased risk for mental disorders, but also for becoming abusers themselves later in life.
- **Disturbed family relationships or parental mental illness**: Children in these circumstances face the potentially dangerous combination of psychologically traumatic disruptions of family life and inconsistent parenting.

While a child with only one of these risk factors may escape the onset of disorder, each additional factor increases the likelihood of a diagnosable mental disorder that interferes with healthy development and functioning. More and more frequently in today's society, children are exposed to multiple risk factors. For example, children born to adolescents are more likely to grow up in poverty and are often victims of abuse or neglect. Children who have been exposed prenatally to drugs typically are born to mothers who received little or no prenatal care. To minimize these outcomes and the potential development of mental disorders, it is necessary to reduce the factors that put children at risk, to enhance protective factors such as social support and competency, and to increase the availability of treatment services for those in need.

Children with Serious Emotional Disturbance

Of the approximately eight million children in America with a diagnosable mental disorder, nearly half are severely disordered. These three to four million children have one or more disorders under the category "serious emotional disturbance", or SED. A number of children with SED are impaired in many functions of daily life. Common symptoms of youth with SED include:

- difficulty developing and maintaining personal relationships;
- difficulty communicating with parents and other loved ones;
- difficulty in learning alongside others in a classroom;
- dropping out of school;

- running away from home;
- feeling hopeless, helpless, and worthless;
- feelings of frustration;
- aggressive behavior; and
- feeling that no one in their lives understands them including parents, teachers, and friends.

This symptomology, when left un- or undertreated, can quickly manifest into more dangerous patterns of behavior. Children with SED often turn to substance abuse to "self-medicate." Some chose suicide as a coping mechanism, and often times succeed. Children with SED are often looked down upon as failures. Their emotional difficulties are frequently construed as the fault of poor upbringing, lack of communication, love, and support. What is often forgotten is that they have important needs that can and must be met. Services to meet the mental health needs of children with SED and their families should be available in the home, the school, and in the community.

What School and Community-Based Mental Health Services are Presently Available for Children?

Treatment Services

...there continues to be a disproportionate ratio of students to mental health professionals in many school systems across the country.

When they are available, school-based mental health services are generally provided in the school by school psychologists, social workers, and counselors. These mental health professionals offer counseling and consultation to students and school staff. They are trained to recognize the warning signs of emotional and behavioral disorders and positioned to intervene in a time of crisis. Since 1960, behavioral interventions have been incorporated in the public school. The use of cognitive interventions (such as self-control and social skills training) have been increasingly utilized among teachers and mental health professionals. Although these interventions have proven successful, there continues to be a disproportionate ratio of students to mental health professionals in many school systems across the country. Without appropriate staff to carry out the necessary service and treatment modalities, a child's ongoing mental health needs cannot be met — thereby inhibiting his or her ability to learn and succeed.

Research indicates that the most effective way to treat a child with a mental disorder is in the least restrictive environment. Services should be provided in the school and in the community as well. Community treatment programs, such as intensive in-home services, day treatment, partial hospitalization, and those offered through community mental health centers, have yielded positive outcomes in terms of responsiveness to therapy and cost-effectiveness. Certain day treatment and partial hospitalization programs have been highly extolled because the therapeutic component of treatment is balanced with an educational program. Services provided by community mental health centers include treatment, prevention, consultation, and education services — most often provided in an outpatient setting.

In 1975, federal legislation proclaimed that all children, including those with mental disorders or SED, have a right to a free and appropriate education. This legislation — formerly known as the Education for All Handicapped Children Act, but currently referred to as the Individuals with Disabilities Education Act (IDEA) — provides federal assistance to states and localities to deliver individualized special education and related services to students with disabilities. However today, fifteen years after the legislation was authorized, the federal government is only spending about $4 million for this demonstration program (Part C of IDEA).

Despite the legislation, children with SED remain the most underserved population of children with disabilities. According to a joint report by the National Mental Health Association and the Federation of Families for Children's Mental Health, *All Systems Failure*, "mental health and special education programs are so badly failing these children that they have the highest drop-out rate of any group of children with disabilities (43-50%). They have lower grades, fail more often, and have a lower rate of promotion than other students with disabilities. They are placed in restrictive settings far more frequently than necessary. They are under-identified by special education programs, and are a low priority for state and local mental health programs."[6]

Prevention Services

Just as important as providing services to children with mental disorders or SED, is the need to provide preventive services to those children who are at risk for developing these problems. Unfortunately, while much rhetoric has been devoted to the pursuit of this ideal, the reality is that school and community-based preventive mental health services have yet to become a priority

for the federal government and most state governments. Thus, preventive mental health services that are provided by schools around the nation are done so on a sporadic basis.

Preventive mental health services intervene in a deliberate, positive and culturally-sensitive way to promote mental health and/or counteract harmful circumstances before they cause disorder or disability. While prevention within mental health is generally a young field, scientific research over recent decades has led to the development of numerous environmental interventions. These interventions contribute to the development of positive mental health or avert the onset of mental health related problems, including mental disorders. The overwhelming majority of researched and evaluated preventive interventions have been targeted to meet the needs of school-aged youth.

The role of the school in preventing mental-emotional disabilities is critical. The primary job of the school is to develop the competence of students, most obviously academic competence. However, academic and social competence are highly interrelated. Behavior problems obviously interfere with the child's ability to master academic tasks, as do low self-esteem and stress.

The National Mental Health Association's Commission on the Prevention of Mental-Emotional Disabilities acknowledged the pivotal role of the school in preventing mental disorders.[7] In its landmark 1986 report, the Commission stated:

> *"The role of the school in preventing mental-emotional disabilities is critical. The primary job of the school is to develop the competence of students, most obviously academic competence. However, academic and social competence are highly interrelated. Behavior problems obviously interfere with the child's ability to master academic tasks, as do low self-esteem and stress."*

Scant federal dollars have been invested in the prevention of mental disorders in children. The National Institute of Mental Health (NIMH) has a small prevention research branch that has been the single greatest source of prevention research over the past decade. While NIMH research had produced some well-evaluated school based prevention programs, there has been no federal investment in the widespread implementation of these programs in schools around the country.

In 1992, the federal Center for Mental Health Services (CMHS), an agency of the Substance Abuse and Mental Health Services Administration, was established by Congress (P.L. 102-321). Within CMHS, Congress established a prevention demonstration program which would, among other things, support demonstrations to evaluate the most promising prevention models for dealing with the mental health problems of school-aged youth. Unfortunately, no funds were appropriated for this program in fiscal year 1993. Advocates will need to work with Congress to ensure funding for this program in Fiscal Year 1994 and beyond.

Next Steps: What Can We Do To Improve Children's Mental Health Services?

In order to improve the current patchwork of school and community-based mental health services provided to children, it is critical that schools, community agencies, professionals, and parents work together in collaboration. This section describes several small-scale models of such collaboration. These exemplar efforts must be integrated into a framework that provides universal access to students in schools across the nation.

Program Models That Work: Treatment Services

The model treatment plan, which has proven the most successful in treating children with mental disorders, is one that integrates a range of child-serving agencies within a community (education, mental health, child welfare, juvenile justice, etc.) to meet these children's myriad needs. Interagency collaboration keeps children from falling through the cracks. It provides a holistic framework for recognizing, evaluating, and treating a child's disorder.

In 1991, the Select Committee on Children, Youth, and Families of the U.S. House of Representatives examined a number of treatment options that were available to children and youth with mental disorders. The study, *Close to Home*, concluded that community-based systems of care for children are cost-effective, generally producing positive outcomes.[8] Robert Friedman presented testimony to the Committee highlighting his study, *A System of Care for Severely Emotionally Disturbed Children and Youth*.[9] A community-based system of care is a "comprehensive array of services which is organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbance."[10] This system provides services in the child's own community so the family can participate in the treatment process, and so the child's educational track is not disrupted. These services include:

- early identification and intervention;
- assessment;
- crisis services;
- outpatient treatment;
- home-based services;
- day treatment;
- therapeutic foster care and group homes;

- crisis residential treatment;
- inpatient hospitalization;
- respite care; and
- case management.

A single system does not have the resources to face the multiple challenges inherent in developing a comprehensive mental health treatment plan for a child. A coordinated method of service delivery, which involves education, mental health, child welfare, juvenile justice, and other child-serving agencies, is crucial to provide for children's multiple needs.

The unique concept of this system of care is that mental health agencies do not provide all of these services. A single system does not have the resources to face the multiple challenges inherent in developing a comprehensive mental health treatment plan for a child. A coordinated method of service delivery, which involves education, mental health, child welfare, juvenile justice, and other child-serving agencies, is crucial to provide for children's multiple needs. Preliminary data on community-based systems of care show:

- a reduction in out-of-home placements;
- a reduction in utilization of more restrictive and costly service options;
- increased parent satisfaction with services;
- costs avoided or saved through a reallocation of service dollars; and
- functional improvements for children at home and in school.[11]

The United States Congress, in 1984, recognized the importance of a community-based system of care by establishing the Child and Adolescent Service System Program (CASSP). CASSP provides grants and technical assistance to states to plan comprehensive, community-based systems of care to children and adolescents with mental disorders. The goal of CASSP is to direct the service delivery in states and communities toward a philosophy of multi-agency use and interagency coordination. The CASSP program is active in all 50 states. The federal government is currently spending approximately $12 million for this program.

In 1992, Congress enacted the Children's and Communities' Mental Health Systems Improvement Act which was based on the principles of the CASSP program. This five-year program authorizes competitive grants to states and localities for the development of community-based systems of care for children with SED. To be eligible for federal grant money, states must demonstrate that they have such a system of care envisioned to serve their children. The program also mandates that key child-serving agencies coordinate services to meet these children's many needs. Despite an authorization level of $100 million for Fiscal Year 1993, Congress only appropriated $4.9 million for the first year of the program. Both CASSP and the new Children's Mental Health Systems Improvement Act are administered by the Center for

Mental Health Services, an agency of the newly established Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services.

There are many program models of these systems of care across the country. Following is an outline of three of the most promising initiatives.

Ventura Planning Model

Ventura County, California

The Ventura Planning Model is designed to enable youth with SED to remain or be unified with their families, attend and progress in public schools, and not commit crimes. The model is founded on five essential elements:

1) **A clearly defined set of targeted populations** that include those youth who are at greatest risk of out-of-home placement and for whom the public sector already has legal and fiscal responsibility;

2) Measurable goals that are committed to **the preservation of family unity and locally-based treatment;**

3) The development of viable **partnerships** at the policy, planning, and service level between public sector agencies, between the public and private sectors, and between agencies and families;

4) **The development of collaborative program services and standards** that adhere to the service philosophy of family preservation, family reunification, and least restrictive environment — developing service plans tailored to an individual child and family and having available a continuum of service options and settings that cross agency boundaries; and

5) The development of a mechanism and process for **system evaluation** that measures client outcome and costs over time and across programs and ensures system accountability.

Effect Upon Education

Since the initiation of this project, the relationship between mental health and special education has changed. Before this project, therapists in the mental health system did not know how many or which youth served in outpatient services were designated as special education students. Now mental health is fully integrated into the special education process. Entry into the mental health/special education system requires assessment by both agencies. The mental health professional who conducts the assessment becomes part of the student's Individualized Education Planning (IEP) Team. Through this project, a number of service options have been developed combining staff and funds of Mental Health and Special Education. Through local alternative programs, youth can remain in their schools receiving supporting mental health services in conjunction with special education programs.

Contact: Randy Feltman, Chief, Child and Youth Services, Venture County Mental Health, 300 Hillmont Avenue, Ventura, CA 93003 Telephone: (805) 652-6737.

Profiles of Local Systems of Care for Children and Adolescents with Severe Emotional Disturbances (1992). CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

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Stark County System of Care

Stark County, Ohio

The four basic elements central to the philosophy of the Stark County System are:

1) **Interagency collaboration**: the system of care is based upon the premise that children and families have problems which relate to multiple systems and that no one agency can be effective in serving them. Interagency participation is evident in planning and service delivery activities;

2) **Providing services within the home and community**: A belief in providing services to youngsters within their homes and within the community has been evident throughout the development of this system of care. The choices to develop day treatment and home-based services as alternatives to residential services were based upon a strong philosophical commitment to provide services in the least restrictive setting, and to keep youngsters with their families to the greatest extent possible;

3) **Family focus**: The child must be viewed as a member of a family. In this context, a primary role of the system of care is to support positive family functioning. Throughout the planning and delivery of services, the system focuses on the needs of the entire family and on involving parents as partners; and

4) **Strength focus**: There is a need to focus on the child's and family's strengths rather than on pathology. An interagency service planning process, used for difficult cases, centers on the identification of strengths that can be employed creatively in the development of service and treatment plans.

Effect Upon Education

Most of the local school districts in Stark County provide special education services for high incidence problems. For low incidence disabilities, services are provided by the Stark County Board of Education. Among the county-operated special education units are classrooms for youngsters with severe behavioral handicaps. The County Board of Education contracts with the Child and Adolescent Service Center to provide a psychologist to consult with teachers and provide group counseling for youngsters in special education classes.

The Stark County Board of Education also provides school psychologists and other specialized services that the smaller districts cannot afford individually. The largest of the local school districts is the Canton City Schools. The Canton City School System participates actively in the system of care. For example, the day treatment program, which is accessible to all children in Stark County, is a collaborative program between the Canton City Schools, the Child and Adolescent Service Center, and the Department of Human Services. In addition, the Director of Special Education has taken responsibility for sharing information with the other school districts through regularly held roundtables for special education directors.

Contact: Beth Dague, M.A., Children's Coordinator, Stark County Mental Health Board, 800 Mark Avenue North, Suite 1150, Canton, OH 44702 Telephone: (216) 455-6644.

Profiles of Local Systems of Care for Children and Adolescents with Severe Emotional Disturbances (1992). CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Northumberland County System

Northumberland County, Pennsylvania

The philosophy of this system of care is:

1) **Quality Circle**: A major aspect of Northumberland County's philosophy is the concept of the "Quality Circle," a Japanese form of management which includes a process whereby all participants have a role in the ongoing development of the agency's philosophy and practices. The concept of the Quality Circle reflects the desire by the department administration to make decisions only with a broad base of input from service delivery participants ranging from clients, to front line workers, to administrators. The process of the Quality Circle allows all participants to feel that they are part of the decision making process;

2) **Consumer focus**: "The people we serve are the primary focus of our programs." Listening to the "customer" is important. "Customers" include families, other agencies, and the community. When the system is built upon a consumer-driven policy, the child and family become the center of service delivery rather than the agency itself;

3) **Family focus**: Families are seen as the most important resource for children and adolescents. The intervention modalities used in the county are oriented toward the family rather than toward the individual child. Services are delivered to the family as a whole to the extent possible, and, when that is not possible, inclusion of the family remains a primary intervention goal.

Effect Upon Education

Special education services are offered directly by a regional Intermediate Unit operated by the state. It offers a wide range of special education services for children and adolescents with severe emotional disturbances, and it works with the various school districts in mainstreaming efforts. While these school-based special education programs have not directly integrated with the human service agency in the past, they are becoming more cooperative and are being seen as part of the total system.

This is especially true with the Student Assistance Program (SAP), a school-based prevention and early intervention program for children and youth with drug and alcohol problems or at risk for suicide, which is jointly funded by state level education, drug and alcohol, and mental health programs. The Department of Human Services provides a liaison to each SAP team who attends at least 50 percent of its staff meetings. The Department also provides training and technical assistance for all SAP and related school staff who are interested and funds a full-time school liaison position to coordinate these activities.

Contact: Jerry Wolfberg, OD, Northumberland County Human Services, Human Services Building, 370 Market Street, Sunbury, PA 17801 Telephone: (717) 988-4178.

Profiles of Local Systems of Care for Children and Adolescents with Severe Emotional Disturbances (1992). CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Program Models That Work: Prevention Services

Despite the recognized linkage between the educational environment and the prevention of mental disorders in children, no nationwide coordinated system for the delivery of preventive mental health services to school-aged children exists. While the call for various school health reforms, including comprehensive school health education and the establishment of school-based health delivery systems, have gained momentum over the past several years, prevention in mental health has not been overtly stressed in such proposals. As a means of bringing school-based preventive mental health to the policy forefront, Roger P. Weissberg, Ph.D., of the University of Illinois at Chicago, proposed in 1991 the establishment of a new integrated educational model called Comprehensive Social-Competence and Health Education (C-SCAHE).[12] C-SCAHE works by promoting students' positive social and health behavior and preventing negative social and health outcomes. It offers a combination of classroom-based educational activities and collaborative efforts on the part of school personnel, parents, peers, and the community. Combining social skills training with domain-specific knowledge provision (such as substance abuse prevention, AIDS awareness, teenage pregnancy prevention), the goals of C-SCAHE are to educate students so that they:

- develop a positive sense of self-worth and feel capable as they deal with daily tasks, responsibilities, and challenges;
- become socially skilled and get along with others;
- engage in positive and safe health behavior;
- gain motivation to be responsible, ethical, contributing members of their peer group, family, school, and community; and
- develop a set of basic skills, work habits, and values as a foundation for a lifetime of meaningful work.

In proposing C-SCAHE, Weissberg acknowledged that school-based prevention efforts do exist on a sporadic basis in a handful of communities across the country. The best of these programs provide a wide array of services including universally delivered lessons in social competence and interpersonal skills, as well as social support programs to help children in particularly high-risk categories, such as those coping with school transition, parental divorce or bereavement. Weissberg comments, "non-systematic exposures to varying skills-training frameworks can be confusing to students. With greater coordination among programs, it would be possible to apply the same skills framework to an array of

social and health concerns. This would reduce instructional time, increase opportunities for students to master skills, and support generalization of skill application to varied content domains."

In the absence of C-SCAHE or other efforts at comprehensive preventive mental health reform in schools, numerous programs are presently offered in various school districts across the nation. Three model programs are described below. These programs correspond with two areas (social competency development and interventions for persons in situations of extreme stress) that the NMHA Commission on the Prevention of Mental-Emotional Disabilities identified as having immediate potential for prevention. Each of these has the additional distinction of having been awarded the Lela Rowland Prevention Award given annually by NMHA in recognition of programmatic excellence in the prevention of mental disorders and the promotion of mental health.

School Development Program

New Haven, CT

The School Development Program (SDP), developed by James P. Comer, M.D., was established as a collaborative effort between the Yale University Child Study Center and the New Haven, Connecticut Public Schools. Since 1968, the overall goal of the program has been to improve the social climate within schools through the collaboration of parents, students, and staff. SDP was not designed to supplement existing curricula, but rather to encompass the mental health needs of the entire school through developing a process model which requires every member of the school community to invest their time, commitment, and energy. SDP is comprised of three teams, a governance and management team, a mental health team, and a parents' program.

The **Governance and Management Team** represents parents, teachers, students, administrators and support staff. This team develops a Comprehensive School Plan with specific goals in the social climate and academic areas; plans staff development activities based on building level goals in these areas; and conducts periodic assessments which allow the staff to modify the program to meet identified needs and opportunities. Working collaboratively, this team gives a school a sense of direction, and allows everybody to experience a sense of ownership and stake in the outcome of the program.

A mental health staff person serving on the governance and management team helps the team apply child development and relationship knowledge to all their activities. The **Mental Health Team** addresses individual student behavior problems, but focuses equally on preventing problems. They do this by recommending and facilitating changes of school procedures and practices found to be harmful to students, staff, and parents.

Parents participate at all levels through their representatives on the Governance and Management Team and as a parent group working with the staff to plan and support social and academic activities. Parents, along with staff, sponsor projects designed to foster good social climate in the school. They also work as assistants in the classrooms, the cafeteria, and the library, as well as performing other significant functions within the school.

Effect Upon Education

As the Governance and Management Team addresses, in a systematic way, the problems and opportunities in the school, students, staff, and parents all begin to function more effectively. As the hope and energy levels of the staff go up, so do the opportunities and motivation to devote time to planning, which leads to improved curriculum development. Eventually the curriculum and the entire school experience begin to promote overall development among students. The staff development program helps the teachers gain the skills necessary to promote personal, social and academic growth among students. Significant academic and social behavior gains often follow.

Contact: James P. Comer, M.D., Director, Yale Child Study Center, P.O. Box 3333, 230 South Frontage Road, New Haven, CT 06510-8009 Telephone: (203) 785-2548.

Comer, J.P. "A brief history and summary of the School Development Program", New Haven, CT: (un-published).

Social Competency Promotion Program for Young Adolescents (SCPP-YA)

New Haven, CT

The goal of SCPP-YA is to prevent mental-emotional disability, such as anti-social behavior, poor impulse control, and substance abuse. The SCPP-YA program teaches adolescents problem solving skills for application in "real life" situations. It is a school-based program involving young adolescents, who are given intensive instruction in social problem-solving skills while addressing other important issues like human growth and development, AIDS, adolescent pregnancy, sexual activity, and substance abuse.

Adolescents participating in the program learn a cognitive-behavioral approach to problem-solving designed as a six-step "traffic light" model. The first step, or the "red light", is stop, calm down, think before you act. The "yellow light" phase gets children to think about the problem in several steps by expressing how they feel, setting a positive goal, generating possible solutions, and anticipating the consequences. The final step is the "green light" to go ahead and try the best plan.

SCPP-YA has been implemented throughout the public schools in New Haven, CT and has spread to 25 states and 4 countries. Teachers are trained before starting the program and are given on-site coaching during the classroom instruction phase. The curriculum has a 27- lesson module of social problem-solving skills, followed by two 9-lesson modules teaching children how to apply these skills in preventing substance use and high-risk sexual behavior.

Effect Upon Education

Since beginning in 1984, in several studies SCPP-YA has been found to enhance adolescents' problem-solving skills, social relations with peers, as well as their behavioral adjustment (Arthur et al., 1991; Caplan et al., 1992; Weissberg & Caplan, 1992). Beyond these outcomes, students, teachers, and parents as well, have been extremely supportive of the program. Teachers have reported that their students who participate in SCPP-YA feel better about themselves, recognize the negative effects of drugs and try to avoid drugs, recognize risky sexual behaviors, and also recognize how to avoid such risks.

Contact: Roger P. Weissberg, Ph.D., Department of Psychology, University of Illinois at Chicago, (M/C 285), 1007 West Harrison Street, Chicago, IL 60607-7137 Telephone: (312) 413-1012.

National Mental Health Association. *Directory of Model Prevention Programs.* Alexandria, VA: (Author), (in press).

Children of Divorce Intervention Program (CODIP)

Rochester, NY

The changes inherent in divorce pose inevitable stresses for children and adults alike. Sadness, anxiety, anger, resentment, confusion, loyalty conflicts, somatic symptoms, and even guilt are common early reactions in children. The Children of Divorce Intervention Program (CODIP) is a school based, child focused, supportive group intervention that emphasizes timely support. Separate intervention models have been developed for three age groups: K-1st grade, 2nd-3rd grade, and 4th-6th grade children of divorce.

CODIP's goals are to provide needed social support and enhance skills that facilitate adaptive coping. Within that framework, five basic objectives are built into a structured, sequential curriculum. Depth of involvement in these five areas and specific program formats and exercises, however, are adapted to the developmental characteristics of each age group. The goals and objectives of the program are as follows:

1.) *Provide a supportive group environment.* CODIP's format and program exercises are designed to maximize group support throughout. Contacts with peers who have gone through comparable experiences helps to reduce children's sense of isolation and develop a sense of camaraderie and trust.

2.) *Identification and appropriate expression of feelings.* CODIP seeks to enhance children's abilities to identify and appropriately express a range of emotions. In dealing with children's sensitive feelings, leaders are encouraged to maintain a safe group environment where all feelings are accepted.

3.) *Clarifying divorce-related misconceptions.* A major goal is to help children separate divorce-related fears from reality. Over several sessions, the program seeks to reduce children's fears of abandonment, feelings of responsibility for the divorce, and unrealistic fantasies about restoring an intact family. The child's ability to attribute the divorce to external realities, rather than something s/he is, or

CODIP continued

has done, helps to restore diminished self-esteem to overcome feelings of responsibility for the parent's departure.

4.) *Enhancing coping skills.* Enhancing children's coping skills is a key program objective. The program devotes several sessions to training social problem solving, communication skills, and the appropriate expression of anger, using age-appropriate games and techniques to encourage skill acquisition and generalization. Children are taught to differentiate between problems that they can and cannot control. This key distinction helps them master the psychological task of disengaging from interparental conflicts.

5.) *Enhance children's perceptions of self and family.* This final, integrative program unit emphasizes positive qualities in children and families. Children in the midst of stressful life changes often feel different and defective (i.e., "If I were a better kid, my parents would have stayed together"). Several self-esteem building exercises are used to help them focus on their strengths and competencies.

Effect Upon Education

Ten years of research shows that children make significant gains in classroom functioning and other school related competencies, such as frustration tolerance, task orientation, and peer relationships.

Contact: JoAnne Pedro-Carroll, Ph.D., Director, CODIP, Primary Mental Health Project, 575 Mt. Hope Avenue, Rochester, NY 14620 Telephone: (716) 275-2547.

National Mental Health Association. *Directory of Model Prevention Programs.* Alexandria, VA: (Author), (in press).

Recommendations

The existing school and community service base for children who already have mental disorders is but a skeletal framework of what is truly needed to meet the mental health needs of millions of our nation's children. Even more appalling than the present state of child mental health treatment services is the total lack of infrastructure for the delivery of school and community-based preventive mental health services. These inadequacies prompt an urgent call to action in this realm. Fundamental and implicit to each of the following recommendations is a call for collaboration on the part of health and mental health professionals, educators, communities, and families. Furthermore, treatment-oriented and prevention-oriented professionals are encouraged to work together on behalf of the mental health of all children — those at risk and those who already have a mental disorder. Only through such collaboration will we be able to cost-effectively and humanely provide our children with the services they need and deserve in order to succeed in school and in life.

Training

- All school health, mental health, education and administrative personnel should receive appropriate training in the mental health skills necessary to facilitate the development of a school climate conducive to sound mental health in all students;
- Certification and recertification of educators should include coursework in applied child development, child mental health, social behavior, and use of effective learning and discipline practices.

Staffing

- All schools should be staffed with the services of a mental health professional capable of providing treatment and preventive mental health services to students; and consultation and training to faculty and administration. In particular, there should be a push for policies to ensure that sufficient numbers of properly certified teachers are hired to educate children with SED and that sufficient numbers of mental health professionals are available in each school district.

Integration of Successful Prevention Models

- K-12 Comprehensive-Social Competence and Health Education should be integrated into school systems across the country. Within the framework of C-SCAHE, successful school-based preventive mental health programs would be provided.

Legislation

Some current legislation, if enacted and sufficiently funded, would bolster efforts to enhance children's mental health services within schools and communities. Readers are encouraged to mobilize grassroots campaigns to urge Members of Congress to:

- Appropriate more adequate funding for the Child Mental Health Services Program, authorized under Public Law 102-321 (in the Center for Mental Health Services) in Fiscal Year 1994.
- Appropriate more adequate funds for the Prevention Demonstrations program in the Center for Mental Health Services for Fiscal Year 1994.
- Introduce and support legislation which calls for comprehensive programming for children with SED. Such programs should focus on development of appropriate social and interpersonal skills and on academic learning, de-emphasizing behavior modification techniques as a goal in and of themselves.*
- Support current legislation on Comprehensive School Health Education. Incorporate the C-SCAHE model into the legislation.

Advocacy

- Consider supporting the adoption of the recently proposed definition of "children with a serious emotional disturbance" in special education law. States vary in the way they define this population. The current federal regulation has serious problems and is under review. States,

* Also recommended in *All Systems Failure*, (1993), National Mental Health Association and Federation of Families for Children's Mental Health.

however, make significant changes to the federal definition as they operationalize it. A broad-based national coalition has recommended a new definition which is being considered for adoption at the federal level. The new definition has a broad base of support, including the support of the national organizations which represent state special education directors and state commissioners of mental health. (For a copy of the proposed definition, contact NMHA Government Affairs).

- Ensure that community mental health agencies provide back-up services to school systems. Mental health professionals working in schools should have time to provide services to teachers and students, and not be overwhelmed by their responsibility for testing.*

Coalitions

- State and local coalitions should work on behalf of meeting children's mental health needs within schools and communities. The work of the National Health/Education Consortium provides an excellent model for states and communities. Local coalitions should utilize the available resources from NHEC, NMHA and other coalitions and organizations to maximize their ability to effectively advocate.

* Also recommended in *All Systems Failure*, (1993). National Mental Health Association and Federation of Families for Children's Mental Health.

Organizational Resources

National Mental Health Association (NMHA)
1021 Prince Street
Alexandria, VA 22314-2971
(703) 684-7722
Contact Persons:
Sandra J. McElhaney, M.A., Director of Prevention
Matt Russell, Program Director for Government Affairs
Heather Barton, Director of the Prevention Clearinghouse
Linda Greenham, Director of the Mental Health Information Center

The National Mental Health Association (NMHA) is a not-for-profit charitable organization with more than eighty years of success in addressing the mental health needs of our communities, states, and nation. Founded in 1909 as the National Committee for Mental Hygiene by former patient-turned-advocate Clifford W. Beers, NMHA has always depended upon volunteers to change the way America thinks about mental health and mental illness. NMHA volunteers all over the country to work to meet the mental health needs of their communities through support groups, community outreach and education, information and referral programs, patient advocacy, and a wide array of other services. Among the major focuses of NMHA are advocacy for social change; the alleviation of stigma and public misconceptions about metal illnesses; support of research on the causes, prevention, and treatment of mental illnesses; leadership in the prevention of mental illnesses; as well as the provision of referral and educational information to the public. Nationally, NMHA works with the federal government to promote research and mental health services, with the media to keep the public informed about mental health and mental illness, and with other major organizations to ensure that the nation's mental health needs are understood and addressed.

The Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, VA 22314-2971
(703) 684-7710
Contact Person:
Barbara Huff, Executive Director

The Federation of Families for Children's Mental Health (FFCMH) is a national parent-run organization focused on the needs of children and youth with emotional, behavioral or mental disorders and their families. The Federation provides leadership

in the field of children's mental health and develops necessary human and financial resources to meet its goals. The Federation provides information and engages in advocacy regarding research, prevention, early intervention, family support, education, transition services and other services needed by these children and youth and their families.

National Institute of Mental Health (NIMH)
5600 Fishers Lane
Rockville, MD 20857
Contact Persons:

Juan Ramos, Deputy Director for Prevention and Special Projects

NIMH was established in 1949 and is the primary source of Federal funding for research into mental health areas, from prevention to serious emotional disorders. The agency's mission is to improve the treatment and prevention of mental illness primarily through the support and conduct of basic, clinical, and applied service systems research, and to exercise national leadership in disseminating and implementing this expanded knowledge base.

Center for Mental Health Services (CMHS)
5600 Fishers Lane
Rockville, MD 20857
Contact Persons:

Judith Katz-Leavey, Chief of the Technical Assistance Program
Maury Lieberman, Director, Prevention and Program Development Branch

CMHS is the newest federal agency relating to mental health and was established in 1992 under the new Substance Abuse and Mental Health Services Administration (SAMHSA). The Center has primary responsibility for the provision of mental health services, as distinguished from NIMH's responsibility for mental health research. Among other duties, CMHS has been charged by the U.S. Congress to design national goals and priorities for the prevention of mental illness and the promotion of mental health, carry out the Children's Mental Health Services Program and the Child and Adolescent Service System Programs, as well as promote policies and programs which foster independence and protect the legal rights of persons with mental illness.

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National Health/Education Consortium

Good health is a significant determinant of a child's ability to learn and succeed in school. The health and education sectors, however, have historically approached programs and services for children from different perspectives. Recognizing the need for better integration of health and education programs for children, the National Commission to Prevent Infant Mortality and the Institute for Educational Leadership organized the NATIONAL HEALTH/EDUCATION CONSORTIUM in May 1990.

The project is unique in that it has brought together leaders from 57 national health and education organizations, representing nearly 11 million constituents, to bridge the gap between the worlds of health and education and to generate unified action for children. Promoting the full potential of children and providing them with the best opportunities for success will require changes in the systems which currently provide health and education services. Reforms are needed to develop more collaborative and cohesive policies and programs, unify agencies and funding streams, and provide a more comprehensive approach to children's problems.

Toward this end, the NATIONAL HEALTH/EDUCATION CONSORTIUM's activities focus on three major goals: to improve public policy in addressing the need for a better coordinated health and education delivery system; to strengthen communication and dissemination of information between health and education activities and policymakers; and to identify exemplary program models and practices which more effectively integrate health and education services. The Consortium involves educators, health professionals, policymakers, administrators, civic leaders, advocates, and parents in its efforts to bring together the health and education communities in a more integrated fashion.

The Consortium is able to attract high profile business, political, health and education leaders to give visibility and implement its mission at the federal, state, and local levels. It does not represent any particular special interest group, but can bring to bear the weight of national association consortium members on behalf of its mission. In addition, the consortium creates state and local networks across the country that will plant the seeds for similar collaborative efforts at those levels.

The foundation of the Consortium's efforts can be found in the report, *Crossing the Boundaries between Health and Education*, which documents clinical research and programs that exemplify the relationship between children's health and their learning potential. To complement this report, the Consortium is releasing a series of papers which focus on various topics relating to health and education.

The NATIONAL HEALTH/EDUCATION CONSORTIUM is supported by The Prudential Foundation, the Honeywell Foundation, the AT&T Foundation, Metropolitan Life Insurance Company, and the Procter & Gamble Fund. Additional support has been provided by the U.S. Department of Health and Human Services, and the U.S. Department of Education.

For more information, please contact:

The National Commission to Prevent Infant Mortality
Switzer Building, Room 2014
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Washington, DC 20201
(202) 205-8364

OR

Institute for Educational Leadership
1001 Connecticut Ave, NW
Suite 310
Washington, DC 20036
(202) 822-8405

National Health/Education Consortium Members and Profiles

American Academy of Family Physicians: 66,000 physicians

American Academy of Pediatrics: 39,000 physicians

American Association of Colleges for Teacher Education: represents 700 member institutions teacher education programs

American Association of School Administrators: 18,517 school administrators

American College of Nurse-Midwives: 3,000 certified nurse-midwives

American College of Obstetricians and Gynecologists: 29,848 obstetricians and gynecologists

American Dental Association: 138,217 dentists

American Federation of Teachers: 750,000 teachers, para-professionals (teacher aides), school-related personnel, healthcare workers, federal and state employees

American Hospital Association (MCH Section): 5,870 hospitals and physicians

American Indian Health Care Association: represents 36 programs and clinics which focus on the health care of American Indians

American Medical Association: 300,000 physicians

American Nurses Association: 201,000 registered nurses

American Public Health Association: 30,977 physicians, nurses, therapists, health technicians, health support personnel, and other health professionals

American School Food Service Association: 65,000 school food service professionals

American School Health Association: 3,000 health educations, nurses, physicians, and dieticians

American Speech-Language-Hearing Association: 67,393 speech-language pathologists, audiologists, scientists, researchers, and educators

Association for the Care of Children's Health: 4,200 nurses, child life workers, and parent leaders

Association for Supervision and Curriculum Development: 153,000 teachers, school administrators, college professors, and school board members

Association of American Medical Colleges: 126 U.S. medical schools, 450 teaching hospitals, and 92 academic professional societies

Association of Maternal and Child Health Programs: represents maternal and child health programs in 50 states and U.S. territories

Association of Schools of Public Health: represents 13,000 deans, faculty, and students of schools of public health

Association of State and Territorial Dental Directors: represents 58 state and territorial dental directors

Association of State and Territorial Health Officials: represents the 58 health officers from each of the United States and its territories

Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN): 24,000 nurses

Council of Chief State School Officers: represents 56 public officials who head departments of elementary and secondary education in each state and extra-state jurisdiction

The Council of Great City Schools: represents 46 of the largest urban public school districts in the United States

The Elementary School Center: represents 500 child-serving professionals

Healthy Mothers, Healthy Babies Coalition: represents 95 non-profit health education groups, and state and local education groups

National Alliance of Black School Educators: 3,000 African-American teachers for Grades K-12

National Association for Asian and Pacific American Education: 594 members representing administrators, teachers, institutional aids, social workers, mental health workers, and students among others

National Association for the Education of Young Children: 77,000 members representing a wide range of early childhood professionals

National Association for Partners in Education: 5,5000 volunteers, presidents and executives of private businesses, teachers, and administrators

National Association of Children's Hospitals and Related Institutions: represents 108 hospitals

National Association of Community Health Centers: represents 600 health care facilities

National Association of Elementary School Principals: 36,000 elementary school principals, middle school principals, school superintendents, teachers, professors, and instructors

National Association of Hispanic Nurses: 1,000 Hispanic nurses

National Association of Pediatric Nurse Associates and Practitioners: 2,800 pediatric nurse associates and practitioners

National Association of School Nurses, Inc.: 5,800 school nurses

National Association of Secondary School Principals: 41,000 secondary school principals, administrators, guidance counselors, activities directors, and college professors

National Association of Social Workers, Inc.: 137,763 members in all fields of social work

National Association of State Boards of Education: represents 600 state boards of education and their members

National Association of WIC Directors: 624 state directors, nutrition coordinators, and local agency directors

National Black Nurses Association: 7,000 African-American nurses

National Coalition of Hispanic Health and Human Services Organizations (COSSMHO): 700 organizations serving the Hispanic population, representing Hispanic physicians, nurses, and students

National Community Education Association: 1,600 teachers, superintendents, administrators, community education directors and coordinators, faculty and administrators of teacher education institutions and programs, community activists, private businesses, and state administrators

The National Congress of Parents and Teachers: 6.8 million parents, K-12 classroom teachers, principals, school administrators, and students

National Education Association: 2 million K-12 classroom teachers, professors, educational support personnel, and students

National Head Start Association: 150 nationwide agency members and 30 individual members

National Indian Education Association: 2,500 members, most of whom are Native American educators

National Medical Association: 16,000 minority physicians

National Mental Health Association: 550 local affiliate mental health associations representing mental health care providers, clients, and community health care centers

National Perinatal Association: 6,000 physicians, nurses, nurse-midwives, social workers, and consumers of perinatal services

National Rural Health Association: represents 1,750 community, migrant, and homeless health centers and their staffs

National School Boards Association: represents 52 state school board associations

National School Public Relations Association: 2,200 teachers, principals, administrators, retired teachers, students, and public relations personnel

Society for Neuroscience: represents 18,000 neuroscientists

Zero to Three – National Center for Clinical Infant Programs: represents 7,500 programs for high risk children and families, as well as individuals

This document does not necessarily reflect the viewpoints or positions of any of the Consortium's members.